STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151335	A. BUILDING 00 B. WING	08/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT DUNN HOSPITAL INC	1600 23RD ST BEDFORD, IN47421

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S0000	This visit was for a State licensure survey. Facility Number: 004779 Dates: 8-29-11 through 8-30-11 Surveyors: Billie Jo Fritch, RN, BSN, MBA Public Health Nurse Surveyor Deborah Franco, RN Public Health Nurse Surveyor Ken Zeigler Laboratory Surveyor QA: claughlin 09/09/11	S0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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S0406	410 IAC 15-1.4-2(a)(1) (a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: (1) All services, including services furnished by a contractor. Based on document review and interview, the facility failed to include all services, including those services provided by contract, in the facility Quality Assurance and Performance Improvement (QAPI) program to ensure they are provided safely and appropriately. Findings include: 1. Review of facility documents on 8-30-11 lacked evidence that the direct services of pediatrics and EEG's and the contracted service of bioengineering were included in the facility QAPI program to ensure they are provided safely and appropriately. 2. Interview with B#3 on 8-30-11 at 1245 hours confirmed that the direct services of pediatrics and EEG's and the contracted service of bioengineering are not included in the facility QAPI program to ensure	S0406	QI for EEG, Pediatric and Bio Med (Trimedx) services. 1. Corrective Action: EEG: Monitor quarterly turn around for timeliness of physician reading (interpretation)of tests Pediatric QI: Review of all pediatric records with ongoing data collection for: · Assessment of daily weights are documented· Oxygen saturations are measured every shift when applicable· Assessment of immunization status is documented Trimedx: (Bio-Med) Physical Plant will track 10% or 20 pieces of all equipment with preventive maintanence performed on a quarterly basis. Trimedx will submit the list of this equipment to the Safety Committee on a monthly basis. 2. Preventive Action:EEG: Data collection of EEG timely reading turn around time for phyician reading (interpretation).Pediatric QI: Data is collected by the department manager and/or the clinical	09/19/2011

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	they are provided safely and appropriately.		support nurses. The department manager will monitor for any negative trends. See attached data collection sheet. Data is then recorded on the hospital dashboard. Data is also reported at Quality Council and department meetings on a quarterly basis.Trimedx: Physical Plant will review 10% or no less than 20 PM completions on a quarterly basis. Summary will be reviewed at Safety Committee 3. Responsibility: EEG: Cardio-Vascular MgrPediatric:Department Manager & Clinical Support Manager Trimedx: Physical Plant4. Completion date: EEG: Start quarterly data collection 10/01/11. Pediatric completion date:September 2011. Trimedx completion date: September 2011.	
S0556	410 IAC 15-1.5-2(b) (b) There shall be an active, effective, and written hospital-wide infection control program. Included in this program shall be system designed for the identification, surveillance, investigation, control, and prevention of infections and communicable diseases in patients and health care workers. Based on document review and interview, the facility failed to have an effective infection control program to prevent the spread of communicable diseases to patients, visitors, and health care workers.	S0556	Maintaining an efffective Infection Control Program. 1. Corrective Action: Document immunity for new hires & current associates for MMR & Varicella. 2. Preventive Action: A. New hires: Revision of the current pre-hire	10/01/2011

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	Findings include: 1. Review of personnel files on 8-29-11 lacked evidence that 20 of 21 staff members (B# 4, 5, 8, 9, 10, 12, 13, 14, 15, 16 and K# 1-10) had documented reliable proof of immunity to Varicella. 2. Review of personnel files on 8-29-11 lacked evidence that 18 of 21 staff members (B# 4, 8, 10, 12, 13, 14, 15, 16 and K# 1-10) had documented reliable proof of immunity to Rubeola. 3. Interview with B#3 on 8-30-11 at 0915 hours confirmed the findings for the above personnel and confirmed that these staff members do not have documented, reliable proof of immunity to rubeola, or varicella. 4. Interview with B#3 on 8-30-11 at 0915 hours confirms the facility's infection control program does not ensure those without documented, reliable proof of immunity are prevented from working during a community outbreak of rubeola or varicella in order to prevent the spread of communicable diseases to patients, visitors, or other health care workers. 5. On 8-30-2011 at 2:15 PM, review of 14 personnel files and interview with E #3 indicated: A. 14 employees (D #1- D#14) lacking: a. reliable documentation of immunization.		Lab form to include immunity testing for Rubeola & Varicella. (Completed 08/31/2011) B. Current associates: Beginning 10/01/2011 Immunity testing for all associates for MMR & Varicella. (Both categories will receive immunizations as indicated by immunity testing results.) HR & Employee Health Policies will reflect the above revisions. 3. Responsibility: Human Resources Director & Infection Control4. Date of Completion: 30 day increments for immunity testing: October 2011 Last names beginning with A and B November 2011 Last names beginning with C thru F December 2011 Last names beginning with G thru L January 2012 Last names beginning with M thru R February 2012 Last names beginning with S thru V March 2012 Last names beginning with W thru ZFinal completion date is 03/31/2012.	

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	b. reliable documented history of acquired immunity to Rubeola. B. 14 employees (D #1- D#14) lacking: a. reliable documentation of immunization. b. reliable documented history of acquired immunity to Varicella.			

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S0596	410 IAC 15-1.5-2(f)(3)(D)(iii) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: (iii) Cleaning, disinfection, and sterilization. Based on document review and staff interview, the facility failed to practice cleaning and disinfection techniques in accordance with manufacturer's recommendations for Cidex OPA in 1 of 1 Surgical Services department. Findings included: 1. Hospital policy titled " HIGH LEVEL DISINFECTION" last reviewed/revised November, 2010, stated: a. Cidex OPA (ortho-phthaladehnyde) and Metricide (gluteraldehyde 2.6%) are the disinfectant solutions used in the operating room. b. Follow manufacturer's guidelines for use. c. Both solutions may be reused for 14 days if not visibly contaminated.	S0596	Infection Control: High level Disinfection in Surgical Services Dept.1. Corrective Action: Associate re-education regarding proper documentation of testing and usage of High Level Disinfection.2. Preventive Action: weekly audits x 1 month and then quarterly audits of the High Level Disinfection records.Track and counsel associates not compliant with documentation. Summary report will be forwarded to Infection Control. 3. Responsibility: Surgical Services Manager4. Date of Completion: 09/01/2011	09/01/2011

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	d. Completely immerse the device in the disinfectant solution, irrigating any lumens. Soak according to manufacturer's recommendations. Cidex OPA = 12 minutes. 2. At 12:45 PM on August 29, 2011 in the Surgical Services department and in the presence of E #1 and E#9, interview with staff member E #9 indicated: a. Cidex OPA is used to disinfect camera, endoscopic lenses, cystoscopy intruments, and other instrumentation not amenable to steam sterilization. b. The manufacturer's guidelines include instructions that "items must be completely immersed for a minimum of 12 minutes to destroy all pathogenic microorganisms". c. A log book for Cidex OPA is maintained with the following headings: i. date ii. item(s) iii. time in (immersion in disinfectant begins) iv. time out (item removed from disinfecting agent) v. test strip passed and initial of employee responsible for assuring the disinfection of the item(s) d. The log book lacked documentation of compliance with the manufacturer's guidelines for use in the following :			

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	i. 47 of 107 entries of disinfection cycles lacked an entry indicating the time the item(s) were removed from the Cidex OPA. ii. 1 of 107 entries of disinfection cycles lacked an entry indicating the time the item(s) were immersed in the Cidex OPA. 3. Interview at 12:45 PM with E #1 and E #9, E #1 and E #9 confirmed that the facility's policy had not been followed in the above instances and that disinfection could not be determined for items without a "time in" or "time out" entry.			

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S0612	410 IAC 15-1.5-2(f)(3)(D)(xi) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: (xi) A program of linen management for personnel involved in linen handling. Based on observation, document review and interview, the infection control program failed to ensure the linen management policies were followed in 2 of 2 linen storage areas toured. Findings include: 1. While touring the facility on 8-30-11 at 1320 hours in the presence of B#5, linens stored in 2 of 2 storage areas were observed to be stacked on patient stretchers uncovered; one of the storage rooms had 2 ceiling tiles missing from the area where clean linens are stored. 2. Review of facility policy #9256 P titled Ordering, Storage, and Use of Linen on 8-30-11 indicated the following: After linen is inspected, it will be re-folded and placed in the designated closed cabinet in	S0612	TAG S612… 1. Corrective Action: Linen storage is presently in transition. Currently moving all the laundry equipment out and dividing the laundry room into soiled linen and clean linen storage areas. 2. Preventative Action: The clean linen side will have shelves placed for proper storage of clean linen. Until the linen room is completed, linens are stored on second floor in empty rooms. The linen will be covered with a sheet while we are in this transition. An interim linen storage policy has been written and implemented. Compliance will be monitored by the Environmental Services mgr and documented on a checksheet daily x 3 months and then quarterly checks x 1 year with reports forwarded to the Safety Committee. 3.	08/30/2011

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	the Central Sterile Supply. The doors of the cabinets must remain closed to protect the linen from dust. 3. Interview with B#5 on 8-30-11 at 1320 hours confirmed the clean linens are stacked on patient stretchers in 2 of 2 linen storage areas and 2 ceiling tiles are missing from the ceiling of one of the rooms where clean linens are stored. 4. Interview with B#8 on 8-30-11 at 1500 hours confirmed the facility is not following the facility policy regarding linen storage, the clean linens are stacked on patient stretchers in 2 of 2 linen storage areas, and 2 ceiling tiles are missing from the ceiling of one of the rooms where clean linens are stored.		Responsibility: Environmental Services Director & Physical Plant Director4. Completion Date: 8/30/2011 for interim storage. Note: The two (2) missing ceiling tiles were also replaced by the Physical Plant Dept. on 8/30/11.	
S0952	410 IAC 15-1.5-6(d) (d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). **Based on blood transfusion policy review, transfusion document chart reviews and staff interview, the hospital failed to administer**	S0952	Blood Transfusion Administration:1. Corrective Action: Provide quality assurance policy for nursing service which includes associate compliance monitoring.2. Preventive Action:	09/01/2011

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	blood transfusions in accordance with approved medical staff policies and procedure for two of nine patients. **Findings included:** **1. The policy, "Administration of Blood and Blood Products", Policy # PC-58, reviewed 9/01/09, read:** **"At the bedside:...two approved transfusionist must check the following: The Date & Time of issue** **V. Blood/Blood Product Administration:** **D. ...stay with the patient the first 15 minutes of the transfusion,** **monitoring the patient's response and observing for adverse reactions.** **Additional vital signs and the patient's response will be documented on the flow sheet at 60 minutes from Start, and every**		Development of review process in the Laboratory to review all aspects for administration of blood products daily. The CSN and/or Department manager will also continue to review documentation post transfusion. 3. Responsibility: Blood Bank Supervisor with oversight by Laboratory Director. This data element was added to the hospital-wide dashboard. 4. Date of Completion: 09/01/2011	

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	60 minutes from that..." **2. In review of two patients receiving blood units, three of these received-units did not have complete documentation, per policy, on the Blood Transfusion Flow Sheet form including:** **Patient #1** **--Unit #1 administered on 8/26/11 at 1010: The unit was issued from the laboratory at 1052; however, the start time was listed at 1010.** **Patient #5** **--Unit #2 administered on 8/13/11 at 0825: The 1 hour vital reading was documented at 0915 in lieu of 0925.** **--Unit #3 administered on 8/13/11 at 0900: The 1 hour vital reading was documented at 1015 in lieu of 1000.** **3. On 8/29/11 at 2:00 p.m., staff member #S3 acknowledged the above-listed missing**			

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	documentation.			
S1118	410 IAC 15-1.5-8 (b)(2) (b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows: (2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees. Based on observation and interview, the facility created/maintained conditions which could result in hazards to patients, visitors, and staff in 3 of 3 restrooms and 1 of 1 maintenance department. Findings include: 1. While touring the facility on 8-30-11 between 1000 hours and 1400 hours, in the presence of B#5, 2 restrooms outside the radiology department and one restroom outside the cafeteria area were observed to have the emergency pull cords wrapped tightly around the grab bars; pulling on the emergency cords was unsuccessful in activating the emergency enunciator or emergency light resulting in a hazard to patients, visitors, and staff if emergency help were needed. 2. While touring the maintenance	S1118	**Emergency call cords not accessible in public rest rooms and unsecured fire extinguishers in the maintenance department.** 1. Corrective action: Call cords repaired to a shorter length and untied on 8/30/2011. Additionally - House keepers were educated on 09/13/11 to check the cords to determine if properly working when rooms are cleaned. Fire extinguishers were secured on 08/30/2011. **2. Preventative action: Assign housekeepers to check the call cords for accessibilityduring normal cleaning. Env Serv Mgr. will check compliance monthly x 3 months , then quarterly x 1 year. Reports will be forwarded to Safety Committee on a quarterly basis. 3. Responsibility of : Environmental Services Manager and**	08/30/2011

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	department on 8-30-11 at 1055 hours in the presence of B#5, 2 unsecured fire extinguishers were observed on the floor causing a hazard to visitors and staff. 3. Interview with B#5 on 8-30-11 at 1055 hours confirmed 2 unsecured fire extinguishers were on the floor in the maintenance department and that the emergency pull cords were wrapped tightly around the grab bars in 2 restrooms outside the radiology department and one restroom outside the cafeteria and could not be activated by pulling on the cords causing a hazard to patients, visitors, and staff.		**Plant Operations Manager. 4. Date corrected: 8-30-2011.**	
S1166	410 IAC 15-1.5-8(d)(2)(C) (d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows: (C) Appropriate records shall be kept pertaining to equipment maintenance, repairs, and current leakage checks. **Based upon document review and staff interview, the laboratory failed to assure the blood bank alarm had been properly maintained and in working order**	S1166	**Blood Bank refrigerator alarm testing policy. 1. Corrective action: Revise PM procedures to include recording temperatures. 2. Preventative action : Educate Bio med staff of changes. Lab Policy for Blood Bank PM procedure was**	09/28/2011

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	for three of three quarters in 2010 and 2011. **Findings included:** **1. The policy, "Refrigerator Alarm Testing Policy", Policy # BB 39, approved 7/08/11, read:** **"The hospital maintenance department performs the routine alarm checks for the Blood Bank refrigerator. The testing procedure includes a low temperature activation which should be no lower than 1 degree Centigrade (C)"** **2. On 8/29/11 at 11:00 a.m., review of three quarterly certification tests for the blood bank refrigerator, dated 11/01/10, 3/08/11, and 6/11/11 respectively, did not indicate the temperature recorder pen responded to decreased temperature variances in the refrigerator on these dates.** **3. On 8/29/11 at 11:00 a.m., staff**		**correct; requested TriMedex add to their template; Lab modified process to review that BioMed completed tasks. Email sent to Trimedx day of survey. Blood Mgr mgr. will add the PM check to monthly Blood Bank QA report and forward report to Safety Committee monthly x 1 year. 3. Responsibility of: TriMedx (Bio-medical staff). in-house responsibility Blood Bank Supervisor. 4. Date corrected: 9-28-2011**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151335	A. BUILDING 00 B. WING	08/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT DUNN HOSPITAL INC	1600 23RD ST BEDFORD, IN47421

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	member #S12 acknowledged this missing documentation.			
S1168	410 IAC 150-1.5-8 (d)(3) (d) The equipment requirements are as follows: (3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained. Based on observation, document review and interview, the facility failed to ensure that 1 of 1 defibrillators on the medical/surgical ward was discharged at least in accordance with manufacturers recommendations. Findings included: 1. On August 29, 2011 at 2:10 PM during tour of the medical/surgical unit and in the presence of E #1, the crash cart was observed to contain a maintenance checklist log which lacked documentation of daily User Test performance in the year 2011 for: a. 9 dates in January b. 10 dates in February c. 8 dates in March d. 7 dates in April e. 5 dates in May	S1168	**Defibrillator daily testing. 1. Correction action: Document daily testing. 2. Preventative action : Educate staff to perform daily testing and document testing. · Defibrillators are discharged daily· The assigned day shift Med/Surg Code Team nurse performs and documents the user test daily. · The assigned night shift Med/Surg code team nurse will verify the performance of the daily user test. If it has not been completed, this nurse will then perform and document the user test completion. 3. Responsibility: Clinical Support Nurse and Dept. Mgr.4. Date of completion: 9-06-2011**	09/06/2011

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	f. 5 dates in June g. 6 dates in July h. 7 dates in August 2. Medtronic LIFEPAK 12 Operating Instructions state the recommended maintenance schedule includes: a. "User Test" to be completed daily. b. The User Test, when selected and activated, performs self-tests; charges to 10 Joules and discharges internally; and prints a Pass/Fail report. 3. Interview with E #1 on 08/30/11 at 2:15 PM confirmed lack of documentation.			

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S1172	410 IAC 15-1.5-8(e)(1)(A)(B)(C) (e) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, shall be kept clean and orderly in accordance with current standards of practice as follows: (1) Environmental services shall be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following: (A) Asepsis (B) Cross-infection; and (C) Safe practice.			
	Based on observation and interview, the facility failed to maintain the ceiling tiles in appropriate order in 1 of 1 housekeeping departments to maintain cleanliness and order. Findings include: 1. While touring the facility on 8-30-11 at 1325 hours, in the presence of B#5, 2 ceiling tiles were observed to be missing from the ceiling in the housekeeping area; one of the missing ceiling tiles was propped against the wall below the area of the missing tiles with a large dark brown stain on the tile. 2. Interview with B#5 on 8-30-11 at 1325 hours confirmed there are 2 missing	S1172	Ceiling tiles missing in housekeeping areas.1. Corrective Action: Replace stained ceiling tiles.2. Preventive Actions: Educate Plant Operations staff on importance of replacing tiles. Physical Plant staff will report and place work tickets to replace stained tiles on a timely basis. 3. Responsibility: Plant Operations Manager and EOC tours to monitor on monthly rounding. This report is forwarded to Safety Committee on a quarterly basis. 4. Date of correction: 09/28/2011	09/28/2011

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	ceiling tiles in the housekeeping area and confirmed the presence of one of the tiles propped against the wall below the area of the missing tiles with a large dark brown stain on the tile.			